practicable outlay. The existing system encourages the worst possible service for the bare minimum of outlay.—I am, etc.,

Kingswinford, Staffs. ARTHUR M. PLANT.

Present State of Medicine, 1842

SIR,—In regard to the present state of affairs may I quote from the records of the Colchester Medical Society ?

"On Tuesday, 2 July 1842, a numerous meeting of the members of the society was held at the Cups Hotel to consider the present state of the medical profession. Dr. Roger Muren was called to the chair and observed that the object of the meeting was to obtain that protection which at the present moment they might be said to be almost destitute of. There was no profession in the world more assailed than the medical profession. . . . They were always the first to be called in cases of illness and the last and the least thought of afterwards . . . their charges were brought into question and disputed. . . .

"This was the treatment which the medical profession sometimes met with and which he was sorry to say was in a great measure attributable to the want of unanimity amongst its members. . . .

"He sincerely hoped that every gentleman present would meet such conduct as it should be met and that one and all would unite, heart and hand, to maintain the respectability and usefulness of the profession to which they belonged. (Cheers.)

"The terms proposed by the Tendring Guardians were then unanimously rejected."

—I am, etc.,

Colchester, Essex. D. R. T. CLENDON.

The Working Party

SIR,—In the *B.M.J. Supplement* for 18 April (p. 136) a list is given of doctors forming the Fraser Working Party. It surely is an omission of some import that there is no doctor on that list from the whole of the West Country or Wales.—I am, etc.,

Bristol. B. W. HILL.

Misleading Memorandum

SIR,—The Revised Memorandum to the Review Body (*Supplement*, 6 June, p. 219) is grossly misleading in the paragraphs which follow the quotation from the Gillie Report.

The young doctor desiring to become a good general practitioner is also faced with a considerable period of postgraduate training, competing with his specializing colleagues for hospital appointments and, until disillusionment of general practitioners of the last five years became apparent, he too faced uncertainty and severe competition in securing entry to good general practice, as the table of advertised vacancies confirms. Having achieved his coveted appointment, in 4 or 5 years, he must look forward to a lifetime of part-time unpaid study in order to keep pace with progress in an ever-widening sphere of service. He too must have a vocational drive which, in the light of paragraphs 20–30 of the Memorandum, many might classify as pathological.

Those who drafted this part of the Memorandum appear to compare the prospects of the potential consultant of 1964 with those of the general practitioner of 1924. Will our general-practitioner representatives ensure that the Review Body correctly understands the true prospects of the new graduate in medicine ?

I write as a general practitioner of thirty years' experience and father of two young graduates in medicine.—I am, etc.,

London N.W.11. BRYANT W. KNIGHT.

Hazard of Needle Biopsy of Lung

SIR,—The January 1964 issue of *Thorax* contains a paper on needle biopsy of the lung using the new Jack needle.[1] In this paper, on the basis of my experience with 96 patients, I make the claim that the procedure is relatively safe and trouble-free. I now report with much regret that a male patient (Case 98) recently died of pulmonary haemorrhage, anoxia, and cardiac arrest after an apparently uneventful needle biopsy. A large pulmonary haemorrhage occurred within a minute of the biopsy and the patient was pronounced dead after 2½ hours, all resuscitative efforts having failed. At necropsy the small puncture in the right lower lobe was difficult to locate and there was no pulmonary laceration. The lung was fibrotic and contained many sarcoid nodules. The haemorrhage must have resulted from the rupture of a large and probably systemic vessel, but this could not be identified. A possible factor of importance was the depth of the puncture (approximately 5 cm.).

It is therefore obvious that the procedure may carry considerable risk and, like liver biopsy, should only be used when strongly indicated. I would strongly recommend that biopsies should be done in the operating theatre with resuscitative measures available and a thoracic surgeon at hand. The above biopsy was done in the ward at another hospital, and there was a slight delay in obtaining endotracheal catheter, sucker, and other resuscitation equipment. The fatal outcome was especially unfortunate as it has been my practice to perform nearly all the other biopsies in the operating theatre. I believe the needle is relatively safe for solid peripheral lesions but in diffuse lung disease it would seem wise to limit the depth of penetration to about 2–3 cm.

I have added a rider to all reprints of the article referring to the above fatality. I feel it is only right that the situation should be more widely publicized through your columns.

—I am, etc., W. G. SMITH.

Sir Charles Gairdner Hospital,
Shenton Park,
West Australia.

REFERENCE

[1] Smith, W. G., *Thorax*, 1964, **19**, 68.

The Cost of Dying

SIR,—This week it was announced that the cost of living index had recently risen a whole point, due in part to the increased price of cigarettes. After all that has been said and published in recent months it is surely irresponsible to continue to tie the cost of cigarettes to the cost of living when it should plainly be added in all fairness to the cost of dying.—I am, etc.,

J. G. C. SPENCER BERNARD.

Aylesbury, Bucks.

Points from Letters

Revised Memorandum

Dr. R. G. TROUP (Hornchurch, Essex) writes: I cannot understand why we continue to undervalue ourselves. We provide a service, 24 hours a day, and we ask for £2,765. *B.M.A. Members Handbook*, page 147, provides an interesting comparison. The remuneration for general practitioners on a sessional basis for sessions of normally 1½ to 2½ hours is (as amended) £4 10s. 6d. per session. This is for undertaking part-time work in Scotland for local authorities.

Most G.P.s do a minimum of 10 consulting sessions and six visiting sessions weekly, making 16 sessions in all. An income based on the rates quoted would be £3,664. In addition there are many hours during which we are on call.

To have asked for less than £4,000 net is sheer folly and we will soon regret it.

"Messenger Boys"

Dr. M. W. A. HAWARD (Midsomer Norton, Somerset) writes: A fresh practice appears to be growing up: the general practitioner is rung up by an admissions clerk, or even a ward sister, to be told that a bed has become available at short notice for one of his patients, and would he please inform the patient. Apparently telegrams are no longer allowed to be sent. A ward sister said that a telegram might alarm a patient. As a result the G.P. adds to his duties that of messenger boy, involving perhaps a journey of several miles.

Much comment on such a duty is superfluous, but I feel this is another reflection of a common attitude of many hospital staffs towards the G.P. Our status will not rise unless such situations are firmly dealt with.

Whole-time and Part-time

Dr. D. A. ALDERSON (Stafford) writes: Although there have been many letters in your columns about the difference between the earnings of family doctors and of consultants none has pointed out that consultants who wish to undertake private practice are required to accept a lower salary scale. If equality is to be the aim negotiators should ask for full-time consultants to be allowed private practice.

It has not been sufficiently emphasized in the past that a "maximum part-time" consultant is, in fact, a "part-paid full-time" consultant. The duties of full-time and maximum part-time consultants are substantially similar, as is shown by the practice of allowing a choice between the two contracts.

Schistosomiasis in the West Indies

Mr. E. F. HONEIN (Manchester 8) writes: I agree with Dr. J. R. L. Roberts's reference (21 March, p. 768) that antimony compounds are at least not safe in the eradication of infection; apart from possible toxic side-effects, I have always wondered whether such treatment increases the incidence of hepatic lesions, leading to cirrhosis and its sequelae of ascites and haematemesis. Antimony is a schistosomicidal, and the dead worms are swept back to the liver and evoke a foreign-protein tissue reaction. I made such an observation in Egypt in respect of the marked prevalence of cirrhosis after the introduction of antimony therapy in 1909.